STATE OF WASHINGTON
Department of
Licensing

SUBSTANCE ABUSE PROFESSIONAL'S

ASSESSMENT / TREATMENT REPORT

This form is to be completed by a substance abuse professional and filed with:

Department of Licensing
PO Box 9030
Olympia, WA 98507

Fax: (360) 664-2298

PLEASE PRINT

DRIVER'S NAME *(Last, First, Middle)*		WASHINGTON DRIVER LICENSE NUMBER
RESIDENCE ADDRESS ☐ PLEASE CHECK IF NEW ADDRESS		DATE OF BIRTH
CITY	STATE	ZIP CODE
MAILING ADDRESS ☐ PLEASE CHECK IF NEW ADDRESS		
CITY	STATE	ZIP CODE
SAP NAME		SAP (AREA CODE) PHONE NUMBER
SAP STREET ADDRESS		
CITY	STATE	ZIP CODE

CHECK ALL APPROPRIATE BOXES

I am reporting:

☐ a drug/alcohol assessment: _____

☐ a drug/alcohol treatment recommendation: _____

☐ that this driver is satisfactorily participating in drug/alcohol treatment/education.

☐ that this driver has successfully completed drug/alcohol treatment/education on:_____.
COMPLETION DATE

CERTIFICATION

I certify under penalty of perjury under the laws of the State of Washington that I am a Department of Transportation qualified substance abuse professional meeting the requirements of 49 CFR Part 40.281 and that the foregoing is true and correct.

X _____ _____
SIGNATURE OF SUBSTANCE ABUSE PROFESSIONAL — DATE SIGNED

_____
PLACE SIGNED

The Department of Licensing has a policy of providing equal access to its services.
If you need special accommodation, call (360) 902-3900 or TTY (360) 664-0116.